STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. BUILDING _____ B. WING _____	R-C 05/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE OF HUNTINGTON	1180 W 500 N HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit to the Investigation of Complaints IN00146007, IN00146074, IN00146410 and IN00146484 completed on 3/27/14. Complaint IN00146007 - Corrected. Complaint IN00146074 - Corrected. Complaint IN00146410 - Corrected. Complaint IN00146484 - Corrected Survey dates: April 30 and May 1, 2014 Facility number: 002910 Provider number: 155692 AIM number: 200345390 Survey Team: Shelley Reed, RN TC Census bed type: SNF: 21 SNF/NF: 43 Residential: 54 Total: 118 Census payor type: Medicare: 11 Medicaid: 16 Other: 91 Total: 118 Sample: 6 Heritage of Huntington was found to be in	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 compliance with 42 CFR Part 483, Subpart B and 410 IAC in regard to the PSR to the Investigation of Complaints IN00146007, IN00146074, IN00146410 and IN00146484. Quality review completed by Debora Barth, RN.	{F 000}		